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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
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BY [Signature] ANALYST

10 BEFORE THE
11 MEDICAL BOARD OF CALIFORNIA
12 DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

13 In the Matter of the Second Amended
14 Accusation Against:

Case No. 8002016020957

15 PAUL GILBERT JOHNSON, M.D.
16 P.O. Box 3699
Seal Beach, CA 90740

SECOND AMENDED ACCUSATION

17 Physician's and Surgeon's Certificate
18 No. G 18771,

Respondent.

20 Complainant alleges:

21 PARTIES

22 1. Kimberly Kirchmeyer (Complainant) brings this Second Amended Accusation solely
23 in her official capacity as the Executive Director of the Medical Board of California, Department
24 of Consumer Affairs (Board).

25 2. On or about July 20, 1970, the Medical Board issued Physician's and Surgeon's
26 Certificate No. G 18771 to Paul Gilbert Johnson, M.D. (Respondent). The Physician's and
27 Surgeon's Certificate was in full force and effect at all times relevant to the charges brought
28 herein and will expire on July 31, 2020, unless renewed.

JURISDICTION

3. This Second Amended Accusation, which supersedes the First Amended Accusation filed on March 14, 2019, is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states:

“(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

“(1) Have his or her license revoked upon order of the board.

“(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

“(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

“(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

“(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

“(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.”

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1 5. Section 2234 of the Code, states, in pertinent part:

2 “The board shall take action against any licensee who is charged with
3 unprofessional conduct. In addition to other provisions of this article, unprofessional
4 conduct includes, but is not limited to, the following:

5 “(a) Violating or attempting to violate, directly or indirectly, assisting in or
6 abetting the violation of, or conspiring to violate any provision of this chapter.

7 “(b) Gross negligence.

8 “(c) Repeated negligent acts. To be repeated, there must be two or more
9 negligent acts or omissions. An initial negligent act or omission followed by a
10 separate and distinct departure from the applicable standard of care shall constitute
11 repeated negligent acts.

12 “(1) An initial negligent diagnosis followed by an act or omission medically
13 appropriate for that negligent diagnosis of the patient shall constitute a single
14 negligent act.

15 “(2) When the standard of care requires a change in the diagnosis, act, or
16 omission that constitutes the negligent act described in paragraph (1), including, but
17 not limited to, a reevaluation of the diagnosis or a change in treatment, and the
18 licensee’s conduct departs from the applicable standard of care, each departure
19 constitutes a separate and distinct breach of the standard of care.

20 “...”

21 6. Section 2266 of the Code states:

22 “The failure of a physician and surgeon to maintain adequate and accurate
23 records relating to the provision of services to their patients constitutes unprofessional
24 conduct.”

25 7. Unprofessional conduct under section 2234 of the Code is conduct which breaches
26 the rules or ethical code of the medical profession, or conduct which is unbecoming a member in
27 good standing of the medical profession, and which demonstrates an unfitness to practice
28 medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

1 **FIRST CAUSE FOR DISCIPLINE**

2 **(Gross Negligence)**

3 8. Respondent Paul Gilbert Johnson, M.D. has subjected his Physician's and Surgeon's
4 Certificate No. G 18771 to disciplinary action under sections 2227 and 2234, as defined by 2234,
5 subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of
6 Patients A, B, C, D. and E,¹ as more particularly alleged herein:²

7 **Patient A**

8 9. On or about July 15, 2011, Patient A, a then 51-year old male, presented for an initial
9 consultation for anxiety and pain management.

10 10. From on or about July 2011, through on or about April 2013, Respondent provided
11 care and treatment to Patient A for, among other things, neck pain, back pain, and anxiety.

12 11. From on or about July 2011, through on or about April 2013, Respondent prescribed
13 several controlled substances to Patient A, including, but not limited to, Vicodin ES³ (7.5/750),
14 Ambien⁴ (10 mg), Xanax⁵ (1 mg), Xanax (2 mg), and diazepam⁶ (10 mg).

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16 _____
17 ¹ Patient identities have been withheld for patient privacy purposes. Respondent is aware of the
18 identities of the patients referred to herein.

19 ² Conduct occurring more than seven (7) years from the filing date of this Second Amended
20 Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

21 ³ Vicodin ES is a brand name for the drug combination of 7.5 mg of hydrocodone and 750 mg of
22 acetaminophen. It is a Schedule II controlled substance pursuant to Health and Safety Code section
23 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.
24 When properly prescribed and indicated, it is used for the treatment of moderate to moderately severe pain.

25 ⁴ Ambien is a brand name for zolpidem, a Schedule IV controlled substance pursuant to Health
26 and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and
27 Professions Code section 4022. Ambien is a benzodiazepine analog. When properly prescribed and
28 indicated, it is commonly used to treat insomnia.

⁵ Xanax is a brand name for alprazolam, a Schedule IV controlled substance pursuant to Health
and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and
Professions Code section 4022. It is an anti-anxiety medication in the benzodiazepine family.

⁶ Diazepam is a Schedule IV controlled substance pursuant to Health and Safety Code section
11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.
Diazepam is a long-acting benzodiazepine. When properly prescribed and indicated, it is used to treat
anxiety, seizures and muscle spasms.

1 12. Between on or about July 2011, and April 2013, Respondent saw Patient A at
2 approximately five (5) office visits, including, but not limited to: July 15, 2011, January 9, 2012,
3 March 23, 2012, October 25, 2012, and April 9, 2013.

4 13. Between on or about July 2011, and April 2013, Respondent's progress notes for his
5 interactions with Patient A are sparse and often illegible.

6 14. On or about July 15, 2011, Patient A reported experiencing extreme stress, family
7 history of alcoholism, and prior medications including Xanax (2 mg) three times per day and
8 Ambien. Records for this visit indicate Respondent issued prescriptions to Patient A for Xanax (2
9 mg) three times per day, and Ambien (10 mg). Respondent's notes for this visit, show no
10 documentation of Patient A's pain level, no discussion regarding the risks, benefits, or side effects
11 of Ambien and Xanax, and no discussion regarding the high dosage level of Ambien being
12 prescribed or the reasoning for such a high dose.

13 15. On or about January 9, 2012, Patient A presented for a check up. Records for this
14 visit indicate Respondent issued prescriptions to Patient A for Xanax (2 mg) three times per day,
15 and Ambien (10 mg). Respondent's notes for this visit, show no documentation of Patient A's
16 pain level, no discussion regarding the risks, benefits, or side effects of Ambien and Xanax, and
17 no discussion regarding the high dosage level of Ambien being prescribed or the reasoning for
18 such a high dose. Respondent's notes for this visit also do not mention whether Patient A's pain,
19 anxiety, or sleep quality was improving or declining.

20 16. On or about March 23, 2012, Patient A presented with complaints of chronic back
21 pain and a request to refill previous medications for Valium and Vicodin. Records for this visit
22 indicate Respondent issued prescriptions to Patient A for Valium (10 mg) and Vicodin ES
23 (7.5/750). Respondent's notes for this visit, show no documentation of Patient A's pain level, no
24 discussion regarding the risks, benefits, or side effects of Valium and Vicodin ES, the rationale
25 for switching from Xanax to Valium, or the risks of taking them in combination with Ambien and
26 Xanax. Respondent's notes for this visit also do not mention whether Patient A's pain, anxiety,
27 or sleep quality was improving or declining.

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1 17. On or about October 25, 2012, Patient A presented requesting refills of his
2 medications. Records for this visit indicate Respondent issued prescriptions to Patient A for
3 Valium (10 mg), Vicodin ES (7.5/750), and Ambien (10 mg). During this visit, Respondent
4 lowered Patient A's prescription for Ambien in half, from 60 tablets to 30 tablets, without any
5 documentation regarding the reasoning for this change. Respondent's notes for this visit also
6 show no documentation of Patient A's pain level, no discussion regarding the risks, benefits, or
7 side effects of Ambien, Xanax, Valium or Vicodin ES, or the risks associated with taking them in
8 combination. Respondent's notes for this visit also do not mention whether Patient A's pain,
9 anxiety, or sleep quality was improving or declining.

10 18. On or about April 9, 2013, Patient A presented for a check up and prescription refills.
11 Records for this visit indicate Respondent issued prescriptions to Patient A for Xanax (2 mg),
12 Ambien (10 mg) and Vicodin ES (7.5/750). Respondent's notes for this visit, show no
13 documentation of Patient A's pain level, no discussion regarding the risks, benefits, or side effects
14 of Ambien, Xanax, Valium or Vicodin ES, or the risks associated with taking them in
15 combination. Respondent's notes for this visit also do not mention whether Patient A's pain,
16 anxiety, or sleep quality was improving or declining.

17 19. Throughout Respondent's care and treatment of Patient A, Respondent did not
18 discuss an overall treatment plan, identify objectives and goals, provide sufficient information
19 regarding the risks of the medications prescribed or the use of them in combination with alcohol,
20 perform periodic reviews to evaluate Patient A's progress toward treatment objectives, refer
21 Patient A to a specialist for additional evaluation and treatment, or consult with a specialist to
22 determine the possibility of alternative treatment modalities.

23 20. Throughout Respondent's care and treatment of Patient A with chronic opioid
24 therapy, Respondent did not conduct an adequate history and physical examination, perform
25 appropriate testing to assess for risk of substance abuse, misuse, or addiction, provide sufficient
26 information to obtain informed consent, establish an opioid management plan, require more
27 frequent office visits, or perform adequate monitoring regarding compliance.

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1 21. On or about April 11, 2013, Respondent was notified by the coroner's office that
2 Patient A had passed away.

3 22. According to Patient A's Controlled Substance Utilization Review and Evaluation
4 System⁷ (CURES) report, from on or about November 2011, through on or about April 2013,
5 based upon prescriptions and refills issued or authorized by Respondent, Patient A obtained
6 approximately 900 tablets of Vicodin ES (7.5/750).

7 23. According to Patient A's CURES report, from on or about November 2011, through
8 on or about April 2013, based upon prescriptions and refills issued or authorized by Respondent,
9 Patient A obtained approximately 900 tablets of diazepam (10 mg).

10 24. According to Patient A's CURES report, from on or about November 2011, through
11 on or about April 2013, based upon prescriptions and refills issued or authorized by Respondent,
12 Patient A obtained approximately 720 tablets of Xanax (1 mg).

13 25. According to Patient A's CURES report, from on or about November 2011, through
14 on or about April 2013, based upon prescriptions and refills issued or authorized by Respondent,
15 Patient A obtained approximately 630 tablets of Xanax (2 mg).

16 26. According to Patient A's CURES report, from on or about November 2011, through
17 on or about April 2013, based upon prescriptions and refills issued or authorized by Respondent,
18 Patient A obtained approximately 1,080 tablets of Ambien (10 mg).

19 27. Respondent committed gross negligence in his care and treatment of Patient A, which
20 included, but is not limited to:

21 A. Paragraphs 9 through 26, above, are hereby incorporated by reference and
22 realleged as if fully set forth herein;

23 _____
24 ⁷ The Controlled Substance Utilization Review and Evaluation System (CURES) is a program
25 operated by the California Department of Justice (DOJ) to assist health care practitioners in their efforts to
26 ensure appropriate prescribing of controlled substances, and law enforcement and regulatory agencies in
27 their efforts to control diversion and abuse of controlled substances. (Health & Saf. Code, § 11165.)
28 California law requires dispensing pharmacies to report to the DOJ the dispensing of Schedule II, III, and
IV controlled substances as soon as reasonably possible after the prescriptions are filled. (Health & Saf.
Code, § 11165, subd. (d).) It is important to note that the history of controlled substances dispensed to a
specific patient based on the data contained in CURES is available to a health care practitioner who is
treating that patient. (Health & Saf. Code, § 11165.1, subd. (a).)

- 1 B. Respondent failed to document and/or develop a treatment plan or document
2 and/or identify objectives for which a treatment plan could be evaluated,
3 including the failure to discuss or document Patient A's reported pain levels, sleep
4 quality, or anxiety improvement;
- 5 C. Respondent failed to document or sufficiently inform Patient A of the risks and
6 benefits associated with the use of the prescribed controlled substances, including
7 the failure to discuss the risks associated with the combined use of opioids and
8 benzodiazepines, the failure to discuss the additional risks associated with a
9 family history of alcoholism, and the failure to advise against combining them
10 with alcohol;
- 11 D. Respondent failed to perform periodic evaluations regarding Patient A's progress
12 toward treatment objectives, including the failure to document any change in pain
13 level, sleep quality, or anxiety improvement;
- 14 E. Respondent failed to discuss with Patient A or refer Patient A for additional
15 consultation, evaluation and treatment, in order to achieve treatment objectives,
16 including the failure to enlist the aid of relevant specialists to determine the
17 underlying cause of Patient A's issues or suggest alternative treatments; and
- 18 F. Respondent failed to maintain adequate and accurate medical records regarding
19 his care and treatment of Patient A, including the failure to document critical
20 patient-care related discussions.

21 **Patient B**

22 28. On or about December 29, 2009, Patient B, a then 32-year old male, presented for an
23 initial consultation for anxiety and pain management. Respondent's notes for this visit indicate
24 Patient B admitted being a prior alcoholic.

25 29. From in or around 2009, through in or around 2018, Respondent provided care and
26 treatment to Patient B for, among other things, pain, depression, anxiety, fatigue, and
27 hypertension.

28 ///

1 30. From in or around 2012, through in or around 2018, Respondent prescribed several
2 controlled substances to Patient B, including, but not limited to, oxycodone⁸ (30 mg), Percocet⁹
3 (10/325), Endocet¹⁰ (10/325), Norco¹¹ (10/325), lorazepam¹² (2 mg), Ambien (10 mg), and
4 Zaleplon¹³ (10 mg).

5 31. In or around 2012, Respondent saw Patient B at approximately five (5) office visits,
6 including, but not limited to: March 8, 2012, April 5, 2012, September 7, 2012, November 9,
7 2012, and December 27, 2012. Respondent's notes for his interactions with Patient B during
8 these visits are sparse and often illegible.

9 32. On or about March 8, 2012, Patient B presented with complaints of arthritis and body
10 aches. During this visit, Patient B informed Respondent that he had been receiving Gabapentin¹⁴
11 (800 mg) from another provider. Respondent issued a prescription to Patient B for Gabapentin
12 (800 mg).

13
14 ⁸ Oxycodone is an opioid and is classified as a Schedule II controlled substance pursuant to Health
15 and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and
16 Professions Code section 4022.

16 ⁹ Percocet is a brand name for the drug combination of oxycodone (2.5 mg, 5 mg, 7.5 mg, or 10
17 mg) and acetaminophen (325 mg). See Footnote 8, above, regarding oxycodone.

17 ¹⁰ Endocet is a brand name for the drug combination of oxycodone (10 mg) and acetaminophen
18 (325 mg). Oxycodone is an opioid and is classified as a Schedule II controlled substance pursuant to
19 Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and
20 Professions Code section 4022.

20 ¹¹ Norco is a brand name for the drug combination of hydrocodone (5 mg, 7.5 mg, or 10 mg) and
21 acetaminophen (325 mg). Hydrocodone is a Schedule II controlled substance pursuant to Health and
22 Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions
23 Code section 4022. When properly prescribed and indicated, it is used for the treatment of moderate to
24 moderately severe pain. The DEA has identified opioids, such as Hydrocodone, as a drug of abuse.
(Drugs of Abuse, DEA Resource Guide (2015 Edition), at p. 43.)

23 ¹² Lorazepam, brand name Ativan, is a Schedule IV controlled substance pursuant to Health and
24 Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions
25 Code section 4022. It belongs to a group of drugs called benzodiazepines.

25 ¹³ Zaleplon, brand name Sonata, is a Schedule IV controlled substance pursuant to Health and
26 Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions
27 Code section 4022.

27 ¹⁴ Gabapentin is an anti-epileptic drug commonly used to treat seizures and epilepsy. It is
28 classified as a dangerous drug pursuant to Business and Professions Code section 4022.

1 33. On or about March 12, 2012, Patient B presented to an emergency department with
2 complaints of body aches and pain. After a thorough review of systems, Patient B was
3 discharged and provided information regarding osteoarthritis. Records for this encounter are
4 maintained in Respondent's chart for Patient B.

5 34. On or about April 5, 2012, Patient B was seen by Respondent at an office visit, during
6 which Patient B informed Respondent of his recent visit to the emergency department.
7 Respondent's notes for this visit indicate Patient B informed Respondent he was not satisfied with
8 the care provided at the hospital. Respondent's notes for this visit also indicate a discussion with
9 Patient B's fiancé; however, the topic of discussion is not documented.

10 35. On or about September 5, 2012, Patient B's mother submitted several records to
11 Respondent regarding psychiatric treatment Patient B was receiving from another provider. The
12 submitted documents included Patient B's records for a visit on July 12, 2007, in which the
13 provider notes Patient B's history of polysubstance abuse, completion of three weeks at an
14 inpatient detoxification facility, and Patient B's admitted recent consumption of alcohol and
15 Norco. The submitted documents also included Patient B's records for a more recent visit on
16 May 15, 2012, with the same provider, in which the physician assessed Patient B with the
17 following diagnoses: bipolar, anxiety, panic, and attention deficit hyperactive disorder. Records
18 for these encounters are maintained in Respondent's medical chart for Patient B.

19 36. On or about September 7, 2012, Patient B presented for a follow up visit with
20 Respondent. Respondent's notes for this visit show no discussion regarding the psychiatric
21 records submitted by Patient B's mother.

22 37. On or about November 9, 2012, Patient B presented for a follow up visit with
23 Respondent. Respondent's notes for this visit again show no discussion regarding the psychiatric
24 records submitted by Patient B's mother.

25 38. Throughout Respondent's care and treatment of Patient B in 2012, Respondent did
26 not discuss an overall treatment plan, identify objectives and goals, provide sufficient information
27 regarding the risks of the medications prescribed or the use of them in combination with alcohol,
28 perform periodic reviews to evaluate Patient B's progress toward treatment objectives, or consult

1 with Patient B's psychiatrist or other treating physicians to confirm reported medications or
2 determine the possibility of alternative treatment modalities.

3 39. In or around 2013, Respondent saw Patient B at approximately three (3) office visits,
4 including, but not limited to: January 18, 2013, September 12, 2013, and October 21, 2013.
5 Respondent's notes for his interactions with Patient B during these visits are sparse and often
6 illegible.

7 40. On or about January 18, 2013, Patient B presented for a one-month check up visit.
8 According to Respondent, no medications were prescribed during this visit. However, records
9 show Respondent issued a prescription to Patient B for lorazepam, Gabapentin, and Seroquel¹⁵ on
10 this date. According to Respondent, at the previous visit, on or about December 27, 2012,
11 Respondent believed Patient B obtained his prescription for Seroquel from his psychiatrist.
12 However, Respondent's records show no indication of this discussion.

13 41. Throughout Respondent's care and treatment of Patient B in 2013, Respondent did
14 not discuss an overall treatment plan, identify objectives and goals, provide sufficient information
15 regarding the risks of the medications prescribed or the use of them in combination with alcohol,
16 perform periodic reviews to evaluate Patient B's progress toward treatment objectives, or consult
17 with Patient B's psychiatrist or other treating physicians to confirm reported medications or
18 determine the possibility of alternative treatment modalities.

19 42. In or around 2014, Respondent saw Patient B at approximately five (5) office visits,
20 including, but not limited to: January 2, 2014, March 5, 2014, June 26, 2014, September 23,
21 2014, and October 23, 2014.

22 43. On or about March 5, 2014, Patient B presented for a follow up visit with Respondent
23 after a recent surgery on his left elbow. Respondent's notes for this visit indicate Respondent
24 prescribed 30 tablets of Percocet (10/325) to Patient B, with no documented discussion regarding
25 Patient B's pain level, or the risks, benefits, or side effects of Percocet.

26
27 ¹⁵ Seroquel is the brand name for quetiapine, commonly used to treat schizophrenia, bipolar
28 disorder and depression. It is classified as a dangerous drug pursuant to Business and Professions Code
section 4022.

1 44. On or about June 26, 2014, Patient B presented for a follow up visit after a recent
2 hospitalization reported on June 22, 2014. Respondent's notes for this visit indicate Patient B
3 informed Respondent that his orthopedic surgeon switched Patient B's prescription from Percocet
4 to Norco, and that Patient B's psychiatrist had prescribed him Suboxone.¹⁶ Respondent's notes
5 for this visit show no discussion regarding whether Suboxone was being prescribed for pain or
6 substance abuse issues.

7 45. On or about September 23, 2014, Patient B presented for a follow up visit with
8 Respondent. During this visit, Patient B's girlfriend was in attendance. Respondent's notes for
9 this visit indicate Patient B reported having another appointment with his psychiatrist and that he
10 had resumed drinking alcohol again. Notes for this visit indicate Respondent urged Patient B not
11 to drink alcohol.

12 46. On or about October 23, 2014, Patient B presented for a follow up visit with
13 Respondent. Respondent's notes for this visit indicate Patient B reported being prescribed a high
14 dose of Ambien by his psychiatrist, but still experiencing issues with sleep. Notes for this visit
15 indicate Respondent issued a prescription to Patient B for 30 tablets of Ambien (10 mg), with no
16 documented discussion regarding the reason for issuing an additional prescription for Ambien, or
17 a discussion regarding the risks, benefits, or side effects of Ambien.

18 47. Throughout Respondent's care and treatment of Patient B in 2014, Respondent did
19 not discuss an overall treatment plan, identify objectives and goals, provide sufficient information
20 regarding the risks of the medications prescribed or the use of them in combination with alcohol,
21 perform periodic reviews to evaluate Patient B's progress toward treatment objectives, or consult
22 with Patient B's psychiatrist or other treating physicians to confirm reported medications or
23 determine the possibility of alternative treatment modalities.

24 48. Throughout Respondent's care and treatment of Patient B with opioid therapy in
25 2014, Respondent did not conduct an adequate history and physical examination, perform

26
27 ¹⁶ Suboxone is a brand name for buprenorphine and naloxone, a Schedule III controlled substance
28 pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to
Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the
treatment of pain as well as addiction to narcotic pain relievers.

1 appropriate testing to assess for risk of substance abuse, misuse, or addiction, provide sufficient
2 information to obtain informed consent, establish an opioid management plan, require more
3 frequent office visits, or perform adequate monitoring regarding compliance.

4 49. In or around 2015, Respondent saw Patient B at approximately five (5) office visits,
5 including, but not limited to: July 23, 2015, October 15, 2015, November 5, 2015, November 30,
6 2015, and December 22, 2015.

7 50. On or about July 23, 2015, Patient B presented with complaints of pain and injury to
8 his body, claiming he had been attacked by several law enforcement officers approximately one
9 month earlier. Included in Respondent's chart for Patient B are records of Patient B's hospital
10 visit on June 26, 2015, after Patient B was arrested for being under the influence of a controlled
11 substance. Records for this encounter are maintained in Respondent's chart for Patient B.
12 Respondent's notes for Patient B's July 23, 2015 visit indicate Respondent prescribed 120 tablets
13 of Norco (10/325) and 120 tablets of oxycodone (30 mg) to Patient B, and that Patient B agreed
14 this would be a "one-time prescription" that would not be issued again.

15 51. On or about October 5, 2015, Patient B presented to an emergency department with
16 complaints of injury after he reportedly fell from a tree. After a thorough review and evaluation,
17 Patient B was determined to be stable with no emergent condition and discharged with a
18 prescription for Norco (10/325). According to the hospital records, Patient B indicated he did not
19 want Norco, and requested a prescription for Percocet (10/325) instead. Records for this
20 encounter are maintained in Respondent's chart for Patient B.

21 52. On or about October 15, 2015, Patient B presented for a follow up visit with
22 Respondent, claiming total body pain due to the recent fall. Respondent's notes for this visit
23 indicate Respondent prescribed 150 tablets of Percocet (10/325) and 120 tablets of Roxicodone¹⁷
24 (30 mg) to Patient B, with no documented discussion regarding Patient B's pain level, or any
25 discussion regarding the risks, benefits, or side effects of Percocet and Roxicodone.

26
27 ¹⁷ Roxicodone is a brand name for oxycodone, a Schedule II controlled substance pursuant to
28 Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and
Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of
moderate to severe pain.

1 53. On or about November 5, 2015, Patient B presented for a follow up visit with
2 Respondent. Respondent's notes for this visit indicate Respondent prescribed another 150 tablets
3 of Percocet (10/325) to Patient B, with no documented discussion regarding Patient B's pain
4 level, or any discussion regarding the risks, benefits, or side effects of Percocet.

5 54. On or about November 30, 2015, Patient B presented for a follow up visit with
6 Respondent. Respondent's notes for this visit indicate Respondent prescribed another 180 tablets
7 of Percocet (10/325) to Patient B, with no documented discussion regarding Patient B's pain
8 level, or any discussion regarding the risks, benefits, or side effects of Percocet. Notes for this
9 visit indicate Respondent informed Patient B he would no longer prescribe oxycodone (30 mg) to
10 Patient B.

11 55. On or about December 22, 2015, Patient B presented for a follow up visit with
12 Respondent. Respondent's progress notes for this visit indicate Respondent prescribed another
13 120 tablets of Percocet (10/325) to Patient B, with no documented discussion regarding Patient
14 B's pain level, or any discussion regarding the risks, benefits, or side effects of Percocet. Notes
15 for this visit indicate Respondent referred Patient B to a neurologist for evaluation.

16 56. Throughout Respondent's care and treatment of Patient B in 2015, Respondent did
17 not discuss an overall treatment plan, identify objectives and goals, provide sufficient information
18 regarding the risks of the medications prescribed or the use of them in combination with alcohol,
19 perform periodic reviews to evaluate Patient B's progress toward treatment objectives, or consult
20 with Patient B's psychiatrist or other treating physicians to confirm reported medications or
21 determine the possibility of alternative treatment modalities.

22 57. Throughout Respondent's care and treatment of Patient B with opioid therapy in
23 2015, Respondent did not conduct an adequate history and physical examination, perform
24 appropriate testing to assess for risk of substance abuse, misuse, or addiction, provide sufficient
25 information to obtain informed consent, establish an opioid management plan, require more
26 frequent office visits, or perform adequate monitoring regarding compliance.

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1 58. In or around 2016, Respondent saw Patient B at approximately six (6) office visits,
2 including, but not limited to: January 26, 2016, February 23, 2016, March 31, 2016, June 9,
3 2016, July 7, 2016, and September 2, 2016.

4 59. On or about February 23, 2016, Patient B presented requesting a refill of his
5 medications. Respondent's notes for this visit indicate Respondent prescribed 186 tablets of
6 Percocet (10/325) to Patient B, with no documented discussion regarding Patient B's pain level,
7 or any discussion regarding the risks, benefits, or side effects of Percocet.

8 60. On or about March 31, 2016, Patient B presented requesting a refill of his
9 medications. Respondent's notes for this visit indicate, Patient B's girlfriend accompanied
10 Patient B during this visit and Patient B indicated he was ready to stop taking oxycodone.
11 Respondent's notes for this visit show no documented discussion regarding a tapering plan to
12 lower Patient B's oxycodone. Patient B's girlfriend informed Respondent that Patient B had been
13 snorting his medications. Respondent's notes for this visit show no documentation of this
14 discussion or information provided by Patient B's girlfriend.

15 61. On or about April 6, 2016, Patient B underwent a neurological consultation with
16 another provider who submitted his neurological examination and report to Respondent. The
17 neurological report is initialed by Respondent and indicates the following: Patient B has a
18 reported history of multiple concussions, occasional falls and black-out episodes.

19 62. On or about April 19, 2016, Patient B underwent an electroencephalogram (EEG) at
20 the request of the neurologist. The EEG report indicated a normal EEG for Patient B. The EEG
21 results are maintained in Respondent's chart for Patient B and is initialed by Respondent.

22 63. On or about June 9, 2016, Patient B presented for a follow up visit with Respondent.
23 Respondent's notes for this visit indicate Patient B reported experiencing extreme pain from the
24 fall and admitted taking Percocet that he had saved up. Notes for this visit indicate Respondent
25 prescribed 120 tablets of Percocet (10/325) to Patient B, with no documented discussion
26 regarding Patient B's pain level, and no discussion regarding the risks, benefits, or side effects of
27 Percocet.

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1 64. On or about July 7, 2016, Patient B presented with complaints of suffering a broken
2 nose after a recent fall. Respondent's notes for this visit indicate Patient B expressed concern
3 with the amount of acetaminophen in Percocet and requested oxycodone instead. Notes for this
4 visit indicate Respondent prescribed 120 tablets of oxycodone (30 mg) to Patient B, with no
5 discussion regarding Patient B's pain level, no discussion regarding liver function tests, no
6 discussion regarding the risks, benefits, or side effects of oxycodone, and no discussion regarding
7 possible abuse or diversion.

8 65. On or about September 2, 2016, Patient B presented with complaints of continued
9 chronic pain. Respondent's notes for this visit indicate Respondent prescribed another 180 tablets
10 of oxycodone (30 mg) to Patient B, with two additional refills authorized for October 2, 2016 and
11 November 2, 2016, with no discussion regarding Patient B's pain level, and no discussion
12 regarding the risks, benefits, or side effects of oxycodone.

13 66. Throughout Respondent's care and treatment of Patient B in 2016, Respondent did
14 not discuss an overall treatment plan, identify objectives and goals, provide sufficient information
15 regarding the risks of the medications prescribed or the use of them in combination with alcohol,
16 perform periodic reviews to evaluate Patient B's progress toward treatment objectives, or consult
17 with Patient B's psychiatrist or other treating physicians to confirm reported medications or
18 determine the possibility of alternative treatment modalities.

19 67. Throughout Respondent's care and treatment of Patient B with opioid therapy in
20 2016, Respondent did not conduct an adequate history and physical examination, perform
21 appropriate testing to assess for risk of substance abuse, misuse, or addiction, provide sufficient
22 information to obtain informed consent, establish an opioid management plan, require more
23 frequent office visits, or perform adequate monitoring regarding compliance.

24 68. In or around 2017, Respondent saw Patient B at approximately three (3) office visits,
25 including, but not limited to: April 28, 2017, August 25, 2017, and December 1, 2017.

26 69. On or about April 28, 2017, Patient B presented requesting a refill of his
27 medications. Respondent's notes for this visit indicate Patient B informed Respondent that his
28 psychiatrist was prescribing him a high dose of Ativan but was slow in authorizing refills, causing

1 Patient B to suffer panic attacks. Respondent's notes for this visit indicate Respondent prescribed
2 90 tablets of Ativan (2 mg) and 180 tablets of oxycodone (10 mg), with no documented
3 discussion regarding the rationale for the change in oxycodone dose, and no discussion regarding
4 the risks, benefits, or side effects of Ativan and oxycodone.

5 70. On or about December 1, 2017, Patient B presented with a cough and cold, and for
6 follow up on previous visits. Respondent's notes for this visit indicate Patient B's mother called
7 and informed Respondent that Patient B had been acting out and requested reevaluation of Patient
8 B's medications. Respondent's notes for this visit indicate Patient B agreed to see his psychiatrist
9 to discuss medication changes. Notes for this visit indicate Respondent prescribed 180 tablets of
10 oxycodone (10 mg), 120 tablets of lorazepam (1 mg), and 60 tablets of Flexeril (10 mg).¹⁸

11 71. Throughout Respondent's care and treatment of Patient B in 2017, Respondent did
12 not discuss an overall treatment plan, identify objectives and goals, provide sufficient information
13 regarding the risks of the medications prescribed or the use of them in combination with alcohol,
14 perform periodic reviews to evaluate Patient B's progress toward treatment objectives, or consult
15 with Patient B's psychiatrist or other treating physicians to confirm reported medications or
16 determine the possibility of alternative treatment modalities.

17 72. Throughout Respondent's care and treatment of Patient B with opioid therapy in
18 2017, Respondent did not conduct an adequate history and physical examination, perform
19 appropriate testing to assess for risk of substance abuse, misuse, or addiction, provide sufficient
20 information to obtain informed consent, establish an opioid management plan, require more
21 frequent office visits, or perform adequate monitoring regarding compliance.

22 73. In or around 2018, Respondent saw Patient B at approximately two (2) office visits,
23 including, but not limited to: January 15, 2018 and May 4, 2018.

24 74. On or about January 15, 2018, Patient B presented for a follow up visit with
25 Respondent. Respondent's notes for this visit indicate Patient B's friend was present for this visit
26 and informed Respondent that Patient B did well when taking his medications as directed, but

27
28 ¹⁸ Flexeril is a brand name for cyclobenzaprine, a muscle relaxant commonly used to treat muscle spasms. It is classified as a dangerous drug pursuant to Business and Professions Code section 4022.

1 does not do well when he misses his medications. Notes for this visit indicate Respondent
2 encouraged Patient B to return to his psychiatrist.

3 75. On or about May 4, 2018, Patient B presented for a follow up visit with Respondent.
4 Respondent's notes for this visit indicate Patient B's mother was present for this visit. Notes for
5 this visit indicate Patient B had seen his psychiatrist and agreed to see a pain management
6 specialist. Notes for this visit indicate Respondent provided Patient B with a list of pain
7 management physicians and prescribed 180 tablets of oxycodone (10 mg) to Patient B.

8 76. According to Respondent's chart for Patient B, on or about June 14, 2018, Patient B
9 reported scheduling an appointment with a pain specialist.

10 77. Throughout Respondent's care and treatment of Patient B in 2018, Respondent did
11 not provide sufficient information regarding the risks of the medications prescribed or the use of
12 them in combination with alcohol, consult with Patient B's psychiatrist or other treating
13 physicians to confirm reported medications, conduct an adequate history and physical
14 examination, perform appropriate testing to assess for risk of substance abuse, misuse, or
15 addiction, provide sufficient information to obtain informed consent, establish an opioid
16 management plan, require more frequent office visits, or perform adequate monitoring regarding
17 compliance.

18 78. Throughout the entirety of Respondent's care and treatment of Patient B, on multiple
19 occasions, Respondent received information from Patient B's friends, family, and other treatment
20 providers, regarding Patient B's potential issues with controlled substances, including opiates.

21 79. Throughout the entirety of Respondent's care and treatment of Patient B, Respondent
22 did not appropriately or timely respond to red flag indications of abuse or diversion exhibited by
23 Patient B or reported by friends, family, and other treatment providers.

24 80. According to Patient B's CURES report, from on or about April 2013, through on or
25 about April 2016, based upon prescriptions and refills issued or authorized by Respondent,
26 Patient B obtained approximately 240 tablets of oxycodone (30 mg).

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1 81. According to Patient B's CURES report, from on or about April 2013, through on or
2 about April 2016, based upon prescriptions and refills issued or authorized by Respondent,
3 Patient B obtained approximately 1,275 tablets of Percocet (10/325) and/or Endocet (10/325).

4 82. According to Patient B's CURES report, from on or about April 2013, through on or
5 about April 2016, based upon prescriptions and refills issued or authorized by Respondent,
6 Patient B obtained approximately 410 tablets of Norco (10/325).

7 83. According to Patient B's CURES report, from on or about April 2013, through on or
8 about April 2016, based upon prescriptions and refills issued or authorized by Respondent,
9 Patient B obtained approximately 120 tablets of lorazepam (2 mg).

10 84. According to Patient B's CURES report, from on or about April 2013, through on or
11 about April 2016, based upon prescriptions and refills issued or authorized by Respondent,
12 Patient B obtained approximately 240 tablets of Ambien (10 mg).

13 85. According to Patient B's CURES report, from on or about April 2013, through on or
14 about April 2016, based upon prescriptions and refills issued or authorized by Respondent,
15 Patient B obtained approximately 30 tablets of Zaleplon (10 mg).

16 86. According to Patient B's CURES report, from on or about April 2013, through on or
17 about April 2016, based upon prescriptions and refills issued or authorized by other medical
18 providers, Patient B also regularly obtained controlled substances, including, but not limited to,
19 lorazepam, alprazolam, clonazepam, Norco and Suboxone.

20 87. Respondent committed gross negligence in his care and treatment of Patient B, which
21 included, but is not limited to:

22 A. Paragraphs 28 through 86, above, are hereby incorporated by reference and
23 realleged as if fully set forth herein;

24 B. Respondent failed to document and/or develop a treatment plan or document
25 and/or identify objectives for which a treatment plan could be evaluated,
26 including the failure to discuss or document Patient B's reported pain levels,
27 anxiety improvement, or sleep quality;

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- 1 C. Respondent failed to document or sufficiently inform Patient B of the risks and
2 benefits associated with the use of the prescribed controlled substances, including
3 the failure to discuss the risks associated with the combined use of opioids and
4 benzodiazepines, and the failure to discuss the additional risks associated with a
5 personal history of polysubstance abuse and reported substance abuse related
6 arrests;
- 7 D. Respondent failed to perform periodic evaluations regarding Patient B's progress
8 toward treatment objectives, including the failure to document any change in pain
9 level, sleep quality, or anxiety improvement;
- 10 E. Respondent failed to discuss with Patient B or timely refer Patient B for
11 additional consultation, evaluation and treatment, in order to achieve treatment
12 objectives, including the failure to enlist the aid of relevant specialists to
13 determine the underlying cause of Patient B's issues or suggest alternative
14 treatments;
- 15 F. Respondent failed to give special attention to Patient B who was at risk for
16 misusing or diverting medications based upon his personal history of reported
17 polysubstance abuse, reported arrest for unlawfully being under the influence of a
18 controlled substance, and reports of abuse from friends, family, and other
19 providers, including the failure to consider a trial chronic opioid therapy, or obtain
20 an opioid management plan; and
- 21 G. Respondent failed to maintain adequate and accurate medical records regarding
22 his care and treatment of Patient B, including the failure to document critical
23 patient-care related discussions.

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1 **Patient C**

2 88. On or about April 13, 2009, Patient C, a then 39-year old female, presented for an
3 initial consultation with Respondent for chronic back pain.

4 89. From in or around 2009, through in or around 2018, Respondent provided care and
5 treatment to Patient C for, among other things, pain, attention deficit disorder, anxiety, insomnia
6 and hypertension.

7 90. From in or around 2009, through in or around 2018, Respondent prescribed several
8 controlled substances to Patient C, including, but not limited to, Percocet, Endocet, alprazolam,
9 Ambien, Phentermine,¹⁹ hydromorphone,²⁰ and dextroamphetamine.²¹

10 91. In or around 2009, Respondent saw Patient C at approximately four (4) visits,
11 including, but not limited to: April 13, 2009, May 5, 2009, July 31, 2009, and September 2,
12 2009. Respondent's notes for his interactions with Patient C during these visits are sparse and
13 often illegible. Respondent's records for Patient C also indicate numerous requests for early
14 refills.

15 92. In or around 2010, Respondent saw Patient C at approximately four (4) visits,
16 including, but not limited to: January 21, 2010, January 29, 2010, June 22, 2010, and October 22,
17 2010. Respondent's notes for his interactions with Patient C during these visits are sparse and
18 often illegible. Respondent's records for Patient C also indicate numerous requests for early
19 refills.

20 _____
21 ¹⁹ Phentermine is a Schedule IV controlled substance pursuant to Health and Safety Code section
22 11057, subdivision (f), and a dangerous drug pursuant to Business and Professions Code section 4022. It
is a stimulant and an appetite suppressant.

23 ²⁰ Hydromorphone, brand name Dilaudid, is a Schedule II controlled substance pursuant to Health
24 and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and
Professions Code section 4022.

25 ²¹ Dextroamphetamine is a Schedule II controlled substance pursuant to Health and Safety Code
26 section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section
27 4022. Adderall is a brand name for dextroamphetamine and amphetamine, a Schedule II controlled
28 substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug
pursuant to Business and Professions Code section 4022. It is an amphetamine salt used for attention-
deficit hyperactivity disorder and narcolepsy.

1 93. In or around 2011, Respondent saw Patient C at approximately two (2) visits,
2 including, but not limited to: May 3, 2011 and September 1, 2011. Respondent's notes for his
3 interactions with Patient C during these visits are sparse and often illegible. Respondent's records
4 for Patient C also indicate numerous requests for early refills.

5 94. In or around 2012, Respondent saw Patient C at approximately two (2) visits,
6 including, but not limited to: April 16, 2012 and June 4, 2012. Respondent's notes for his
7 interactions with Patient C during these visits are sparse and often illegible.

8 95. In or around 2012, Respondent's records for Patient C indicate Patient C made
9 numerous requests for early refills, on dates including, but not limited to: February 24, 2012,
10 May 7, 2012, May 30, 2012, August 17, 2012, September 18, 2012, and December 4, 2012.

11 96. On or about February 16, 2012, Patient C sent an email to Respondent requesting a
12 prescription for Xanax and sleeping medication. According to Respondent's records for Patient
13 C, Respondent issued a prescription to Patient C for 60 tablets of Xanax (0.25 mg) and 30 tablets
14 of Ambien (10 mg). Respondent's records for Patient C show no corresponding patient visit or
15 discussion with Patient C regarding these medications.

16 97. On or about February 24, 2012, Patient C sent an email to Respondent requesting an
17 early refill stating previous issues with a pharmacy refusing to refill her medications.

18 98. On or about April 16, 2012, Patient C presented for a general check-up and refill of
19 medications. Respondent's notes for this visit indicate Respondent prescribed 180 tablets of
20 Percocet (10/325) and 60 tablets of Adderall (20 mg) to Patient C, with no documented discussion
21 regarding Patient C's pain level, or the risks, benefits, or side effects of Patient C's medications.

22 99. On or about May 7, 2012, Patient C sent an email to Respondent requesting an early
23 refill. Patient C exchanged emails with Respondent discussing issues in obtaining prescription
24 refills from Patient C's pharmacist.

25 100. Throughout Respondent's care and treatment of Patient C in 2012, Respondent did
26 not discuss an overall treatment plan, identify objectives and goals, provide sufficient information
27 regarding the risks of the medications prescribed, or perform periodic reviews to evaluate Patient
28 C's progress toward treatment objectives.

1 101. In or around 2013, Respondent saw Patient C at approximately three (3) visits,
2 including, but not limited to: January 17, 2013, July 29, 2013, and August 9, 2013. Respondent's
3 notes for his interactions with Patient C during these visits are sparse and often illegible.

4 102. In or around 2013, Respondent's records for Patient C indicate Patient C made
5 requests for early refills, on dates including, but not limited to: March 11, 2013.

6 103. On or about July 29, 2013, Patient C presented for a follow up visit with Respondent
7 for refills of her medications. Respondent's notes for this visit indicate Patient C has been seeing
8 a psychologist. Respondent's notes for this visit indicate Respondent prescribed 60 tablets of
9 Xanax (0.25 mg) to Patient C, with no documented discussion regarding Patient C's anxiety
10 levels, or the risks, benefits, or side effects of Xanax.

11 104. Throughout Respondent's care and treatment of Patient C in 2013, Respondent did
12 not discuss an overall treatment plan, identify objectives and goals, provide sufficient information
13 regarding the risks of the medications prescribed, or perform periodic reviews to evaluate Patient
14 C's progress toward treatment objectives.

15 105. In or around 2014, Respondent saw Patient C at approximately two (2) visits,
16 including, but not limited to: January 14, 2014 and December 9, 2014. Respondent's notes for
17 his interactions with Patient C during these visits are sparse and his handwritten notes are often
18 illegible.

19 106. On or about January 14, 2014, Patient C presented for a general check-up visit with
20 Respondent. Respondent's notes for this visit indicate Respondent prescribed 180 tablets of
21 Percocet (10/325) and 60 tablets of Adderall (20 mg) to Patient C, with no documented discussion
22 regarding Patient C's pain levels, or the risks, benefits, or side effects of these medications.

23 107. Throughout Respondent's care and treatment of Patient C in 2014, Respondent did
24 not discuss an overall treatment plan, identify objectives and goals, provide sufficient information
25 regarding the risks of the medications prescribed, or perform periodic reviews to evaluate Patient
26 C's progress toward treatment objectives. Furthermore, Respondent's records make no mention
27 of CURES review, urine toxicology screening, or consideration of alternative treatments.

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1 108. In or around 2015, Respondent saw Patient C at approximately one (1) office visit,
2 including, but not limited to: January 20, 2015. Respondent's notes for his interactions with
3 Patient C during this visit are sparse and his handwritten notes are illegible.

4 109. On January 20, 2015, Patient C presented for a visit to discuss recent weight gain and
5 the desire to begin Phentermine. Respondent's notes for this visit indicate Respondent prescribed
6 30 tablets of Phentermine (37.5 mg), 30 tablets of Ambien (10 mg), and 180 tablets of Percocet
7 (10/325), to Patient C, with no documented discussion regarding Patient C's pain levels, or the
8 risks, benefits, or side effects of these medications.

9 110. Throughout Respondent's care and treatment of Patient C in 2015, Respondent did
10 not discuss an overall treatment plan, identify objectives and goals, provide sufficient information
11 regarding the risks of the medications prescribed, or perform periodic reviews to evaluate Patient
12 C's progress toward treatment objectives. Furthermore, Respondent's records make no mention
13 of CURES review, urine toxicology screening, or consideration of alternative treatments.

14 111. In or around 2016, Respondent saw Patient C at approximately one (1) office visit,
15 including, but not limited to: September 30, 2016. Respondent's notes for his interactions with
16 Patient C during this visit are sparse and his handwritten notes are illegible.

17 112. On or about September 30, 2016, Patient C presented for a routine follow up visit
18 with Respondent. Respondent's notes for this visit do not indicate what medications were
19 reviewed or prescribed.

20 113. On or about October 3, 2016, Patient C contacted Respondent's office requesting an
21 early refill of Percocet, stating her medications were lost in the ocean.

22 114. Throughout Respondent's care and treatment of Patient C in 2016, Respondent did
23 not discuss an overall treatment plan, identify objectives and goals, provide sufficient information
24 regarding the risks of the medications prescribed, or perform periodic reviews to evaluate Patient
25 C's progress toward treatment objectives. Furthermore, Respondent's records make no mention
26 of CURES review, urine toxicology screening, or consideration of alternative treatments.

27 115. In or around 2017, Respondent saw Patient C at approximately four (4) visits,
28 including, but not limited to: July 11, 2017, August 10, 2017, November 7, 2017, and November

1 20, 2017. Respondent's notes for his interactions with Patient C during these visits are sparse and
2 his handwritten notes are illegible.

3 116. On or about November 20, 2017, Patient C presented for a visit with Respondent to
4 discuss her blood pressure medication. Respondent's notes for this visit indicate Respondent
5 prescribed 60 tablets of Percocet (10/325) to finish Patient C's previous prescription, with no
6 documented discussion regarding Patient C's pain levels, or the risks, benefits, or side effects of
7 these medications.

8 117. Throughout Respondent's care and treatment of Patient C in 2017, Respondent did
9 not discuss an overall treatment plan, identify objectives and goals, provide sufficient information
10 regarding the risks of the medications prescribed, or perform periodic reviews to evaluate Patient
11 C's progress toward treatment objectives. Furthermore, Respondent's records show minimal
12 physical exam and make no mention of CURES review, urine toxicology screening, or
13 consideration of alternative treatments.

14 118. In or around 2018, Respondent saw Patient C at approximately one (1) office visit,
15 including, but not limited to: June 21, 2018. Respondent's notes for his interactions with Patient
16 C during this visit are sparse and his handwritten notes are illegible.

17 119. On or about May 22, 2018, Respondent sent correspondence to Patient C indicating
18 he can no longer prescribe narcotics and tranquilizers to the same patient, and that Patient C must
19 decide which medication she would like to continue. Respondent's records for Patient C also
20 indicate Respondent made a referral to a pain management specialist on May 22, 2018.

21 120. On or about June 21, 2018, Patient C presented for a follow up appointment and
22 refills of her medications. Respondent's notes for this visit indicate Respondent increased Patient
23 C's medication for Xanax from 0.25 mg to 0.5 mg with no documentation of the reason for this
24 increase. Respondent's notes for this visit indicate Respondent's prescription for Ambien was
25 discontinued with no documentation of the reason for this change. Respondent's notes for this
26 visit indicate Respondent prescribed 180 tablets of Percocet (10/325) to Patient C, with no
27 documented discussion regarding Patient C's pain level, or the risks, benefits, or side effects of
28 Percocet.

1 121. On or about June 21, 2018, Patient C provided a urine sample which tested positive
2 for benzodiazepines and opiates, and negative for oxycodone.

3 122. Throughout Respondent's care and treatment of Patient C in 2018, Respondent did
4 not discuss an overall treatment plan, identify objectives and goals, provide sufficient information
5 regarding the risks of the medications prescribed, or perform periodic reviews to evaluate Patient
6 C's progress toward treatment objectives.

7 123. Throughout the entirety of Respondent's care and treatment of Patient C, Respondent
8 did not appropriately or timely respond to red flag indications of abuse or diversion exhibited by
9 Patient C.

10 124. According to Patient C's CURES report, from on or about January 2014, through on
11 or about January 2017, based upon prescriptions and refills issued or authorized by Respondent,
12 Patient C obtained approximately 4,500 tablets of Percocet (10/325).

13 125. According to Patient C's CURES report, from on or about January 2014, through on
14 or about January 2017, based upon prescriptions and refills issued or authorized by Respondent,
15 Patient C obtained approximately 2,340 tablets of Endocet (10/325).

16 126. According to Patient C's CURES report, from on or about January 2014, through on
17 or about January 2017, based upon prescriptions and refills issued or authorized by Respondent,
18 Patient C obtained approximately 1,500 tablets of alprazolam (0.25 mg).

19 127. According to Patient C's CURES report, from on or about January 2014, through on
20 or about January 2017, based upon prescriptions and refills issued or authorized by Respondent,
21 Patient C obtained approximately 1,140 tablets of Ambien (10 mg).

22 128. According to Patient C's CURES report, from on or about January 2014, through on
23 or about January 2017, based upon prescriptions and refills issued or authorized by Respondent,
24 Patient C obtained approximately 540 tablets of phentermine (37.5 mg).

25 129. According to Patient C's CURES report, from on or about January 2014, through on
26 or about January 2017, based upon prescriptions and refills issued or authorized by Respondent,
27 Patient C obtained approximately 480 tablets of dextroamphetamine (20 mg).

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1 130. According to Patient C's CURES report, from on or about January 2014, through on
2 or about January 2017, based upon prescriptions and refills issued or authorized by Respondent,
3 Patient C obtained approximately 100 tablets of hydromorphone (8 mg).

4 131. Respondent committed gross negligence in his care and treatment of Patient C, which
5 included, but is not limited to:

6 A. Paragraphs 88 through 130, above, are hereby incorporated by reference and
7 realleged as if fully set forth herein;

8 B. Respondent failed to document and/or develop a treatment plan or document
9 and/or identify objectives for which a treatment plan could be evaluated, including
10 the failure to discuss or document Patient C's reported pain levels, anxiety
11 improvement, or sleep quality; and

12 C. Respondent failed to maintain adequate and accurate medical records regarding
13 his care and treatment of Patient C, including the failure to document critical
14 patient-care related discussions.

15 **Patient D**

16 132. In or around 2013, Patient D, a then 33-year old male, was being treated by
17 Respondent for, among other things, chronic back pain.

18 133. From in or around 2013, through in or around 2016, Respondent provided care and
19 treatment to Patient D for, among other things, chronic back pain, anxiety, and adult attention
20 deficit hyperactivity disorder (ADHD).

21 134. From in or around 2013, through in or around 2016, Respondent prescribed several
22 controlled substances to Patient D, including, but not limited to, oxycodone, Norco, Adderall, and
23 alprazolam.

24 135. In or around 2013, Respondent saw Patient D at approximately 3 (three) visits,
25 including, but not limited to: June 27, 2013, August 2, 2013, and November 11, 2013.
26 Respondent's notes for his interactions with Patient D during these visits are sparse and often
27 illegible. Respondent's notes for these visits show no documentation of a discussion with Patient
28 D regarding the cause of his back pain, pain level, review of his CURES activity report, side

1 effects of the medications prescribed, opioid agreement, consideration of urine toxicology
2 screening, or alternative treatments.

3 136. Throughout Respondent's care and treatment of Patient D in 2013, Respondent did
4 not document any discussion regarding an overall treatment plan, identify objectives and goals of
5 treatment, provide sufficient information regarding the risks of the medications prescribed, or
6 perform periodic reviews to evaluate Patient D's progress.

7 137. In or around 2014, Respondent saw Patient D at approximately four (4) visits,
8 including, but not limited to: February 7, 2014, May 19, 2014, September 19, 2014, and
9 December 9, 2014. Respondent's notes for his interactions with Patient D during these visits are
10 sparse. Respondent's notes for these visits show no documentation of a discussion with Patient D
11 regarding the cause of his back pain, pain level, review of his CURES activity report, side effects
12 of the medications prescribed, opioid agreement, consideration of urine toxicology screening, or
13 alternative treatments.

14 138. On or about September 19, 2014, Patient D presented for a follow up visit with
15 Respondent. According to Respondent's records for this visit, Patient D indicated he wanted to
16 change his medication from Xanax to Adderall. No further discussion is documented for the
17 reason for this change. Respondent's records for this visit indicate Respondent prescribed 60
18 tablets of Adderall (30 mg) to Patient D, with no documented discussion regarding the risks,
19 benefits, or side effects of Patient D's medications.

20 139. Throughout Respondent's care and treatment of Patient D in 2014, Respondent did
21 not document any discussion regarding an overall treatment plan, identify objectives and goals of
22 treatment, provide sufficient information regarding the risks of the medications prescribed, or
23 perform periodic reviews to evaluate Patient D's progress.

24 140. In or around 2015, Respondent saw Patient D at approximately one (1) visit,
25 including, but not limited to: August 25, 2015. Respondent's notes for his interactions with
26 Patient D during this visit are sparse. Respondent's notes for this visit shows no documentation
27 of a discussion with Patient D regarding the cause of his back pain, pain level, review of his

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1 CURES activity report, side effects of the medications prescribed, opioid agreement,
2 consideration of urine toxicology screening, or alternative treatments.

3 141. Throughout Respondent's care and treatment of Patient D in 2015, Respondent did
4 not document any discussion regarding an overall treatment plan, identify objectives and goals of
5 treatment, provide sufficient information regarding the risks of the medications prescribed, or
6 perform periodic reviews to evaluate Patient D's progress.

7 142. In or around 2016, Respondent saw Patient D at approximately one (1) visit,
8 including, but not limited to: March 11, 2016. Respondent's notes for his interactions with
9 Patient D during this visit are sparse. Respondent's notes for this visit shows no documentation
10 of a discussion with Patient D regarding the cause of his back pain, pain level, review of his
11 CURES activity report, side effects of the medications prescribed, opioid agreement,
12 consideration of urine toxicology screening, or alternative treatments.

13 143. On or about March 11, 2016, Patient D presented for a follow up visit with
14 Respondent. According to Respondent's records for this visit, Patient D indicated he was
15 recently involved in a motor vehicle accident wherein all of his upper teeth had been knocked out.
16 Respondent's notes for this visit show no further discussion regarding how Patient D was treated
17 as a result of this incident or any medications Patient D may have received from other physicians.

18 144. Throughout Respondent's care and treatment of Patient D in 2016, Respondent did
19 not document any discussion regarding an overall treatment plan, identify objectives and goals of
20 treatment, provide sufficient information regarding the risks of the medications prescribed, or
21 perform periodic reviews to evaluate Patient D's progress.

22 145. Throughout the entirety of Respondent's care and treatment of Patient D, Respondent
23 did not appropriately or timely respond to red flag indications of abuse or diversion exhibited by
24 Patient D.

25 146. Throughout the entirety of Respondent's care and treatment of Patient D, Respondent
26 regularly prescribed to Patient D a combination of opioid and benzodiazepine medications with
27 no documentation of periodic review or discussion with Patient D as to their efficacy or
28 monitoring of these controlled substances.

1 147. Throughout the entirety of Respondent's care and treatment of Patient D, Respondent
2 never ordered X-rays or imaging studies to evaluate the cause of Patient D's back pain.

3 148. Throughout the entirety of Respondent's care and treatment of Patient D, Respondent
4 never sent Patient D for a formal evaluation for ADHD or anxiety.

5 149. According to Patient D's CURES report, from on or about January 2014, through on
6 or about December 2016, based upon prescriptions and refills issued or authorized by
7 Respondent, Patient D obtained approximately 9,120 tablets of oxycodone (30 mg).

8 150. According to Patient D's CURES report, from on or about January 2014, through on
9 or about December 2016, based upon prescriptions and refills issued or authorized by
10 Respondent, Patient D obtained approximately 1,440 tablets of Adderall (30 mg).

11 151. According to Patient D's CURES report, from on or about January 2014, through on
12 or about December 2016, based upon prescriptions and refills issued or authorized by
13 Respondent, Patient D obtained approximately 1,170 tablets of Xanax (2 mg).

14 152. According to Patient D's CURES report, from on or about January 2014, through on
15 or about December 2016, based upon prescriptions and refills issued or authorized by
16 Respondent, Patient D obtained approximately 1,080 tablets of Norco (10/325).

17 153. Respondent committed gross negligence in his care and treatment of Patient D, which
18 included, but is not limited to:

19 A. Paragraphs 132 through 152, above, are hereby incorporated by reference and
20 realleged as if fully set forth herein;

21 B. Respondent failed to document and/or develop a treatment plan or document
22 and/or identify objectives for which a treatment plan could be evaluated, including
23 the failure to discuss or document Patient D's reported pain levels or anxiety levels;

24 C. Respondent failed to document or sufficiently inform Patient D of the risks and
25 benefits associated with the use of the prescribed controlled substances, including
26 the failure to discuss the risks associated with the combined use of opioids and
27 benzodiazepines;

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1 D. Respondent failed to perform periodic evaluations regarding Patient D's
2 progress toward treatment objectives, including the failure to document any change
3 in pain level or anxiety level;

4 E. Respondent failed to discuss with Patient D or timely refer Patient D for
5 additional consultation, evaluation and treatment, in order to achieve treatment
6 objectives, including the failure to enlist the aid of relevant specialists to determine
7 the underlying cause of Patient D's chronic back pain or suggest alternative
8 treatments;

9 F. Respondent failed to give special attention to Patient D who was at risk for
10 misusing or diverting medications, including the failure to obtain an opioid
11 management plan; and

12 G. Respondent failed to maintain adequate and accurate medical records regarding
13 his care and treatment of Patient D, including the failure to document critical
14 patient-care related discussions.

15 **Patient E**

16 154. In or around 2013, Patient E, a then 36-year old male, was being treated by
17 Respondent for, among other things, chronic back pain.

18 155. From in or around 2013, through in or around 2016, Respondent provided care and
19 treatment to Patient E for, among other things, chronic back pain, anxiety, and diabetes.

20 156. From in or around 2013, through in or around 2016, Respondent prescribed several
21 controlled substances to Patient E, including, but not limited to, oxycodone, Norco, methadone,²²
22 clonazepam²³ and alprazolam.

23 157. In or around 2013, Respondent saw Patient E at approximately eight (8) visits,
24 including, but not limited to: May 6, 2013, June 7, 2013, July 1, 2013, July 30, 2013, August 30,

25 ²² Methadone is a Schedule II controlled substance pursuant to Health and Safety Code section
26 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

27 ²³ Clonazepam is a Schedule IV controlled substance pursuant to Health and Safety Code section
28 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It
is an anti-anxiety medication in the benzodiazepine family.

1 2013, October 11, 2013, November 7, 2013, and December 9, 2013. Respondent's notes for his
2 interactions with Patient E during these visits are sparse and often illegible. Respondent's notes
3 for these visits show no documentation of a discussion with Patient E regarding the cause of his
4 back pain, pain level, review of his CURES activity report, side effects of the medications
5 prescribed, opioid agreement, consideration of urine toxicology screening, or alternative
6 treatments.

7 158. Throughout Respondent's care and treatment of Patient E in 2013, Respondent did
8 not document any discussion regarding an overall treatment plan, identify objectives and goals of
9 treatment, provide sufficient information regarding the risks of the medications prescribed, or
10 perform periodic reviews to evaluate Patient D's progress.

11 159. In or around 2014, Respondent saw Patient E at approximately eight (8) visits,
12 including, but not limited to: January 6, 2014, April 1, 2014, June 30, 2014, July 17, 2014,
13 August 26, 2014, September 25, 2014, October 23, 2014, and December 18, 2014. Respondent's
14 notes for his interactions with Patient E during these visits are sparse. Respondent's notes for
15 these visits show no documentation of a discussion with Patient E regarding the cause of his back
16 pain, pain level, review of his CURES activity report, side effects of the medications prescribed,
17 opioid agreement, consideration of urine toxicology screening, or alternative treatments.

18 160. On or about July 17, 2014, Patient E presented for a follow up visit with Respondent.
19 According to Respondent's records for this visit, Patient E requested a letter from Respondent for
20 his employer, indicating Patient E would be tapered off methadone and Xanax. Respondent's
21 notes for this visit indicate a letter was provided to Patient E, however, no tapering doses or
22 instructions are indicated in the records.

23 161. Throughout Respondent's care and treatment of Patient E in 2014, Respondent did
24 not document any discussion regarding an overall treatment plan, identify objectives and goals of
25 treatment, provide sufficient information regarding the risks of the medications prescribed, or
26 perform periodic reviews to evaluate Patient D's progress.

27 162. In or around 2015, Respondent saw Patient E at approximately ten (10) visits,
28 including, but not limited to: January 16, 2015, February 10, 2015, March 12, 2015, March 31,

1 2015, May 14, 2015, June 4, 2015, June 30, 2015, August 21, 2015, October 16, 2015, and
2 November 19, 2015. Respondent's notes for his interactions with Patient E during these visits are
3 sparse. Respondent's notes for these visits show no documentation of a discussion with Patient E
4 regarding the cause of his back pain, pain level, review of his CURES activity report, side effects
5 of the medications prescribed, opioid agreement, consideration of urine toxicology screening, or
6 alternative treatments.

7 163. Throughout Respondent's care and treatment of Patient E in 2015, Respondent did
8 not document any discussion regarding an overall treatment plan, identify objectives and goals of
9 treatment, provide sufficient information regarding the risks of the medications prescribed, or
10 perform periodic reviews to evaluate Patient D's progress.

11 164. In or around 2016, Respondent saw Patient E at approximately three (3) visits,
12 including, but not limited to: January 19, 2016, February 16, 2016, and March 11, 2016.
13 Respondent's notes for his interactions with Patient E during these visits are sparse.
14 Respondent's notes for these visits show no documentation of a discussion with Patient E
15 regarding the cause of his back pain, pain level, review of his CURES activity report, side effects
16 of the medications prescribed, opioid agreement, consideration of urine toxicology screening, or
17 alternative treatments.

18 165. Throughout Respondent's care and treatment of Patient E in 2016, Respondent did
19 not document any discussion regarding an overall treatment plan, identify objectives and goals of
20 treatment, provide sufficient information regarding the risks of the medications prescribed, or
21 perform periodic reviews to evaluate Patient D's progress.

22 166. Throughout the entirety of Respondent's care and treatment of Patient E, Respondent
23 regularly prescribed to Patient E a combination of opioid and benzodiazepine medications with no
24 documentation of periodic review or discussion with Patient E as to their efficacy or monitoring
25 of these controlled substances.

26 167. Throughout the entirety of Respondent's care and treatment of Patient E, Respondent
27 never ordered X-rays or imaging studies to evaluate the cause of Patient E's back pain.

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1 168. Throughout the entirety of Respondent's care and treatment of Patient E, Respondent
2 never sent Patient E for a formal evaluation for anxiety.

3 169. According to Patient E's CURES report, from on or about January 2014, through on
4 or about December 2016, based upon prescriptions and refills issued or authorized by
5 Respondent, Patient E obtained approximately 8,460 tablets of Methadone (10 mg).

6 170. According to Patient E's CURES report, from on or about January 2014, through on
7 or about December 2016, based upon prescriptions and refills issued or authorized by
8 Respondent, Patient E obtained approximately 4,800 tablets of oxycodone (30 mg).

9 171. According to Patient E's CURES report, from on or about January 2014, through on
10 or about December 2016, based upon prescriptions and refills issued or authorized by
11 Respondent, Patient E obtained approximately 450 tablets of Norco (10/325).

12 172. According to Patient E's CURES report, from on or about January 2014, through on
13 or about December 2016, based upon prescriptions and refills issued or authorized by
14 Respondent, Patient E obtained approximately 4,740 tablets of alprazolam (2 mg).

15 173. According to Patient E's CURES report, from on or about January 2014, through on
16 or about December 2016, based upon prescriptions and refills issued or authorized by
17 Respondent, Patient E obtained approximately 1,860 tablets of clonazepam (1 mg).

18 174. Respondent committed gross negligence in his care and treatment of Patient E, which
19 included, but is not limited to:

20 A. Paragraphs 154 through 173, above, are hereby incorporated by reference and
21 realleged as if fully set forth herein;

22 B. Respondent failed to document and/or develop a treatment plan or document
23 and/or identify objectives for which a treatment plan could be evaluated,
24 including the failure to discuss or document Patient E's reported pain levels or
25 anxiety levels;

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- 1 C. Respondent failed to document or sufficiently inform Patient E of the risks and
2 benefits associated with the use of the prescribed controlled substances, including
3 the failure to discuss the risks associated with the combined use of opioids and
4 benzodiazepines;
- 5 D. Respondent failed to perform periodic evaluations regarding Patient E's progress
6 toward treatment objectives, including the failure to document any change in pain
7 level or anxiety level;
- 8 E. Respondent failed to discuss with Patient E or timely refer Patient E for additional
9 consultation, evaluation and treatment, in order to achieve treatment objectives,
10 including the failure to enlist the aid of relevant specialists to determine the
11 underlying cause of Patient E's issues or suggest alternative treatments;
- 12 F. Respondent failed to give special attention to Patient E who was at risk for
13 misusing or diverting medications, including the failure to consider a trial chronic
14 opioid therapy, or obtain an opioid management plan; and
- 15 G. Respondent failed to maintain adequate and accurate medical records regarding
16 his care and treatment of Patient E, including the failure to document critical
17 patient-care related discussions.

18 **SECOND CAUSE FOR DISCIPLINE**

19 **(Repeated Negligent Acts)**

20 175. Respondent Paul Gilbert Johnson, M.D. has further subjected his Physician's and
21 Surgeon's Certificate No. G 18771 to disciplinary action under sections 2227 and 2234, as
22 defined by 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his
23 care and treatment of Patients A, B, C, D, and E, as more particularly alleged herein.

24 **Patient A**

25 176. Respondent committed repeated negligent acts in his care and treatment of Patient A,
26 which included, but are not limited to:

- 27 A. Paragraphs 9 through 27, above, are hereby incorporated by reference and
28 realleged as if fully set forth herein;

- 1 B. Respondent failed to perform and/or document a complete history and physical
2 examination of Patient A throughout his care;
- 3 C. Respondent failed to give special attention to Patient A who was at risk for
4 misusing or diverting medications based upon his family history of alcoholism
5 and reported moderate use of alcohol prior to initiating chronic opioid therapy,
6 including the failure to consider a trial chronic opioid therapy, or obtain an opioid
7 management plan;
- 8 D. Respondent failed to make reasonable efforts to monitor for compliance to ensure
9 the controlled substances and medications prescribed to Patient A were not being
10 diverted, were not excessive or inappropriate; and
- 11 E. Respondent failed to perform urine toxicology screens, review CURES, recognize
12 and explore red flag behavior, or obtain an appropriate opioid agreement with
13 Patient A.

14 **Patient B**

15 177. Respondent committed repeated negligent acts in his care and treatment of Patient B,
16 which included, but are not limited to:

- 17 A. Paragraphs 28 through 87, above, are hereby incorporated by reference and
18 realleged as if fully set forth herein; and
- 19 B. Respondent failed to perform and/or document a complete history and physical
20 examination of Patient B throughout his care; and
- 21 C. Respondent failed to perform urine toxicology screens, review CURES, recognize
22 and explore red flag behavior, or obtain an appropriate opioid agreement with
23 Patient B.

24 **Patient C**

25 178. Respondent committed repeated negligent acts in his care and treatment of Patient C,
26 which included, but is not limited to:

- 27 A. Paragraphs 88 through 131, above, are hereby incorporated by reference and
28 realleged as if fully set forth herein; and

- 1 B. Respondent failed to perform and/or document a complete history and physical
2 examination of Patient C throughout his care;
- 3 C. Respondent failed to document or sufficiently inform Patient C of the risks and
4 benefits associated with the use of the prescribed controlled substances, including
5 the failure to discuss the risks associated with the combined use of opioids and
6 benzodiazepines;
- 7 D. Respondent failed to perform periodic evaluations regarding Patient C's progress
8 toward treatment objectives, including the failure to document any change in pain
9 level, sleep quality, or anxiety improvement;
- 10 E. Respondent failed to discuss with Patient C or timely refer Patient C for
11 additional consultation, evaluation and treatment, in order to achieve treatment
12 objectives, including the failure to enlist the aid of relevant specialists to
13 determine the underlying cause of Patient C's issues or suggest alternative
14 treatments;
- 15 F. Respondent failed to give special attention to Patient C who was at risk for
16 misusing or diverting medications and made numerous requests for early refills
17 and reported several issues in obtaining medication refills from pharmacies;
- 18 G. Respondent failed to make reasonable efforts to monitor for compliance to ensure
19 the controlled substances and medications prescribed to Patient C were not being
20 diverted, were not excessive or inappropriate; and
- 21 H. Respondent failed to perform urine toxicology screens, review CURES, recognize
22 and explore red flag behavior, or obtain an appropriate opioid agreement with
23 Patient C.

24 **Patient D**

25 179. Respondent committed repeated negligent acts in his care and treatment of Patient D,
26 which included, but is not limited to:

- 27 A. Paragraphs 132 through 153, above, are hereby incorporated by reference and
28 realleged as if fully set forth herein; and

- 1 B. Respondent failed to perform and/or document a complete history and physical
2 examination of Patient D throughout his care; and
3 C. Respondent failed to perform urine toxicology screens, review CURES, recognize
4 and explore red flag behavior, or obtain an appropriate opioid agreement with
5 Patient D.

6 **Patient E**

7 180. Respondent committed repeated negligent acts in his care and treatment of Patient E,
8 which included, but is not limited to:

- 9 A. Paragraphs 154 through 174, above, are hereby incorporated by reference and
10 realleged as if fully set forth herein; and
11 B. Respondent failed to perform and/or document a complete history and physical
12 examination of Patient E throughout his care; and
13 C. Respondent failed to perform urine toxicology screens, review CURES, recognize
14 and explore red flag behavior, or obtain an appropriate opioid agreement with
15 Patient E.

16 **THIRD CAUSE FOR DISCIPLINE**

17 **(Failure to Maintain Adequate and/or Accurate Records)**

18 181. Respondent Paul Gilbert Johnson, M.D. has further subjected his Physician's and
19 Surgeon's Certificate No. G 18771 to disciplinary action under sections 2227 and 2234, as
20 defined by 2266, of the Code, in that he failed to maintain adequate and accurate records
21 regarding his care and treatment of Patients A, B, C, D, and E, as more particularly alleged in
22 paragraphs 9 through 180, above, which are hereby incorporated by reference and realleged as if
23 fully set forth herein.

24 **FOURTH CAUSE FOR DISCIPLINE**

25 **(Violations of the Medical Practice Act)**

26 182. Respondent Paul Gilbert Johnson, M.D. has further subjected his Physician's and
27 Surgeon's Certificate No. G 18771 to disciplinary action under sections 2227 and 2234, as
28 defined by 2234, subdivision (a), of the Code, in that he committed a violation or violations of a

1 provision or provisions of the Medical Practice Act in his care and treatment of Patients A, B, C,
2 D, and E, as more particularly alleged in paragraphs 8 through 181, above, which are hereby
3 incorporated by reference and realleged as if fully set forth herein.

4 **FIFTH CAUSE FOR DISCIPLINE**

5 **(General Unprofessional Conduct)**

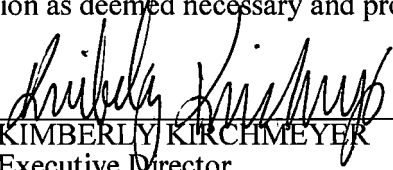
6 183. Respondent Paul Gilbert Johnson, M.D. has further subjected his Physician's and
7 Surgeon's Certificate No. G 18771 to disciplinary action under sections 2227 and 2234 of the
8 Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical
9 profession, or conduct which is unbecoming to a member in good standing of the medical
10 profession, and which demonstrates an unfitness to practice medicine, in his care and treatment of
11 Patients A, B, C, D, and E, as more particularly alleged in paragraphs 8 through 182, above,
12 which are hereby incorporated by reference and realleged as if fully set forth herein.

13 **PRAYER**

14 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
15 and that following the hearing, the Medical Board of California issue a decision:

- 16 1. Revoking or suspending Physician's and Surgeon's Certificate No. G 18771, issued
17 to Respondent Paul Gilbert Johnson, M.D.;
- 18 2. Revoking, suspending or denying approval of Respondent Paul Gilbert Johnson,
19 M.D.'s authority to supervise physician assistants and advanced practice nurses;
- 20 3. Ordering Respondent Paul Gilbert Johnson, M.D., if placed on probation, to pay the
21 Board the costs of probation monitoring; and
- 22 4. Taking such other and further action as deemed necessary and proper.

23 DATED: May 30, 2019

24 
25 KIMBERLY KIRCHMEYER
26 Executive Director
27 Medical Board of California
28 Department of Consumer Affairs
State of California
Complainant

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